



CONTEMPORARY PALLIATIVE CARE IN HEART FAILURE

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Heart Failure Update

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- I will discuss off-label uses of medications.

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Objectives

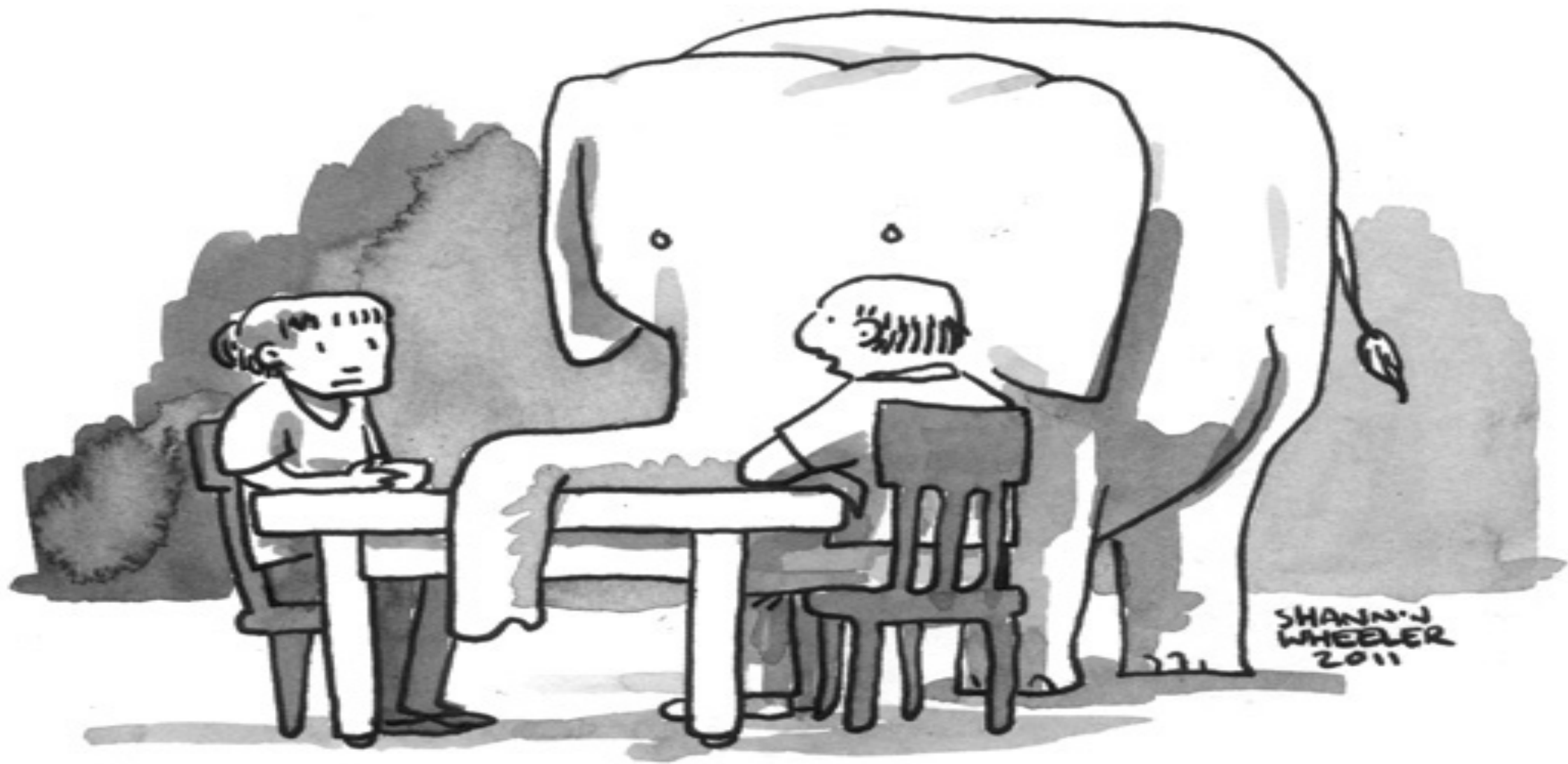
- Describe practical strategies for initiating a discussion on goals of care with HF patients in palliative care
- Review treatment options, including cannabis use, for the management of non-cardiovascular symptoms in HF patients in palliative care
- Discuss approaches to handle requests for medical assistance in dying.

Mr. W.C.

- 73 year old man with ischemic cardiomyopathy, EF 25%.
- Married, one daughter, retired.
- Past medical history includes CABG x 4 in 2004, PCI in 2010, CKD.
- On optimal medical management, CRT-D.
- Recently discharged from hospital following his third admission for heart failure in the last year.
- Creatinine has not recovered to pre-admission baseline.
- First out patient follow up since discharge.

Mrs. H. C.

- 66 year old woman with non ischemic cardiomyopathy, EF 30%.
- Married, 2 children.
- Past medical history includes T2DM with neuropathy, obesity and hypertension.
- On optimal medical therapy, ICD.
- Last hospitalization one year ago when diagnosed with HF.
- Presents for her regular out patient follow up.



"HONESTLY? I PREFERRED WHEN WE
DIDN'T TALK ABOUT THE ELEPHANT"

When and how do we introduce
a palliative care approach?



World Health
Organization

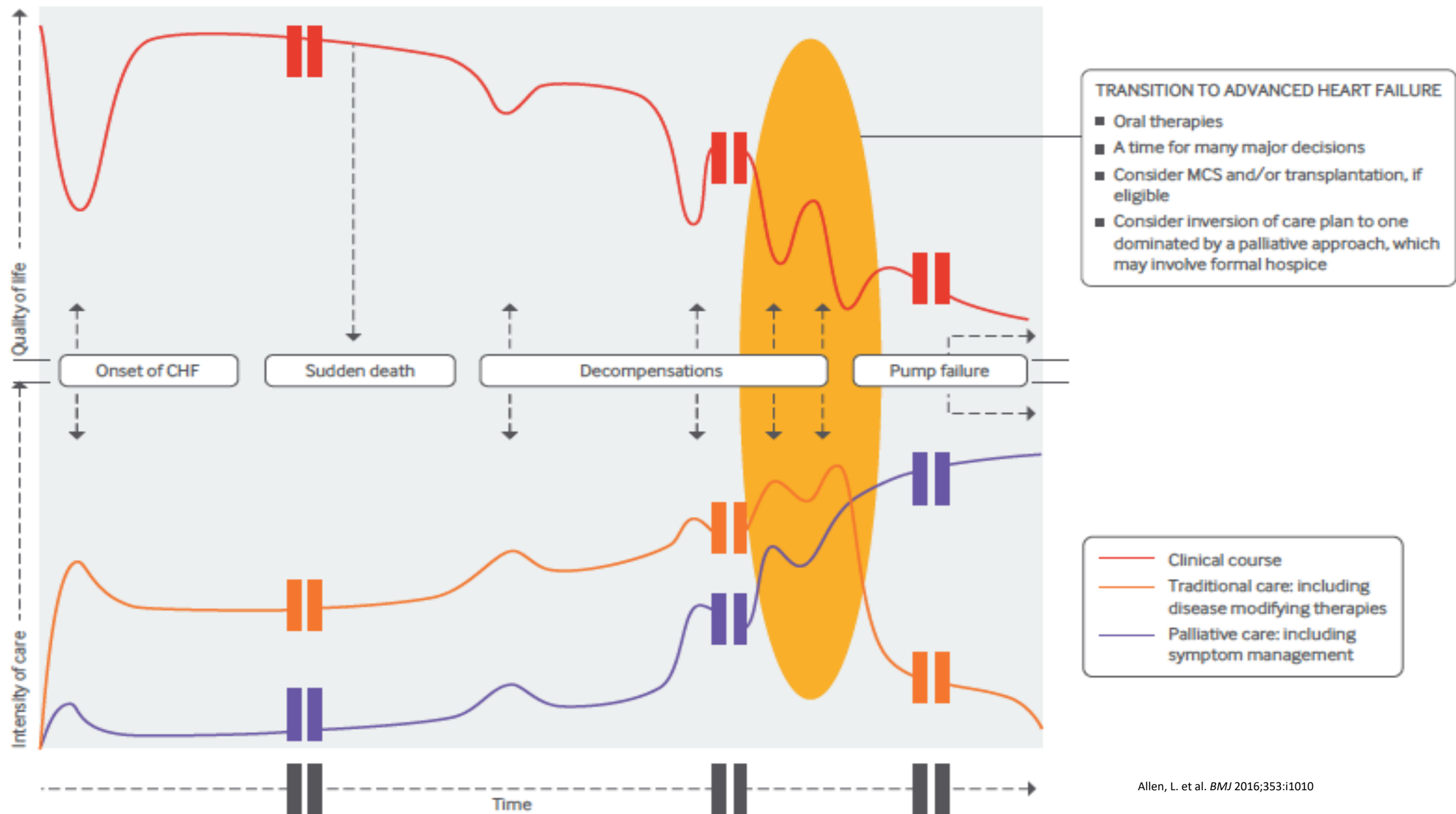
Palliative Care Definition

An approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness

intends ***neither to hasten or postpone*** death

integrates the ***psychological and spiritual*** aspects of patient care

applicable ***early in the course of illness***, in conjunction with other therapies that are intended to prolong life



The Evidence for Palliative Care in HF

- Decreased symptom burden.
- Improved NYHA class.
- Improved quality of life.
- Decreased hospitalization rates.
- Reduced healthcare costs.
- Increased survival ?

J Card Failure. 2012 Dec; 18 (12): 894-899

European Journal of Heart Failure (2014) 16, 1142–1151

Journal of Palliative Medicine 2015. 18 (2).

Heart 2016;102:1100–1108

J Am Coll Cardiology 2017 Jul 18;70(3):331-341

Journal of Palliative Medicine 2017. 20 (1)

Connor SR, et al. J Pain Symptom Manage. 2007 Mar;33(3):238-46.

Annu Rev Public Health 2014. 35: 459-75

Guideline Recommendations

RECOMMENDATION

169. We recommend that clinicians caring for patients with heart failure engage in ongoing discussions with patients and families regarding advance care planning (Strong Recommendation; Very Low-Quality Evidence).
170. We recommend that clinicians engage in ongoing discussions with patients and families regarding advance care planning (Strong Recommendation; Very Low-Quality Evidence).
171. We recommend that the presence of persistent advanced HF symptoms despite optimal therapy be confirmed, ideally by an interdisciplinary team with expertise in HF management, to ensure appropriate HF management strategies have been considered and optimized, in the context of patient goals and comorbidities (Strong Recommendation; Very Low-Quality Evidence).

Ongoing and repeated
discussions regarding
advance care planning.

Guideline Recommendations

RECOMMENDATION

169. We recommend that clinicians caring for patients with HF should initiate and facilitate regular, ongoing, and repeated discussions with patients and family regarding advance care planning (Strong Recommendation; *Very Low-Quality Evidence*).

170. We recommend that clinicians caring for patients with HF should initiate and facilitate discussions with patients and family regarding advance care planning on the basis of assessment of needs and symptoms rather than estimates of remaining life. (*Very Low-Quality Evidence*)

171. We recommend that clinicians caring for patients with HF should initiate and facilitate discussions with patients and family regarding advance care planning on the basis of assessment of needs and symptoms rather than estimates of remaining life. (*Very Low-Quality Evidence*)

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Provision on the basis of
assessment of needs and
symptoms rather than
estimates of remaining life.

Palliative Care Model in HF






CENTRAL ILLUSTRATION Integrating Palliative Care Across the HF Experience

After heart failure (HF) diagnosis, initiate in tandem:


Traditional HF Management

-  Patient assessments: Medical and family histories, physical exam, diagnostic tests, patient-reported outcomes
-  Predict and communicate prognosis
-  Choose therapy
-  Manage "trigger" events
-  Monitor progress as physical function and quality of life declines

Primary Palliative Care

-  Control pain and other symptoms
-  Assist with medical decision-making and advance care planning
-  Assess and reduce emotional distress and burden to patient and family
-  Coordination of care across patient's care team
-  Promote improved quality of life for patient and caregiver

Specialist Palliative Care

-  Consider specialist involvement when problems are especially complex or severe (includes hospice care)

Improving Communication - Advance Care Planning



"My advance directive was for you not to show up."

Advanced Care Planning - Patient Perspective

1. Patients want to discuss prognosis
2. They want to discuss it early in the disease process
3. They want US to initiate the discussion
4. They want to be included in the decision making process.

Advance Care Planning

Evidence suggests:

Improved patient symptoms and anxiety

Reduced psychiatric comorbidity among family members

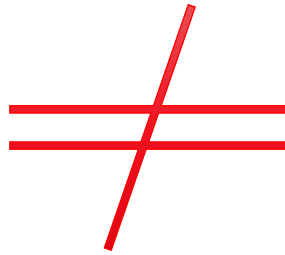
Reduces costs to the healthcare system, increased palliative and hospice use

*Difficult discussions now will simplify
difficult discussions in the future.*

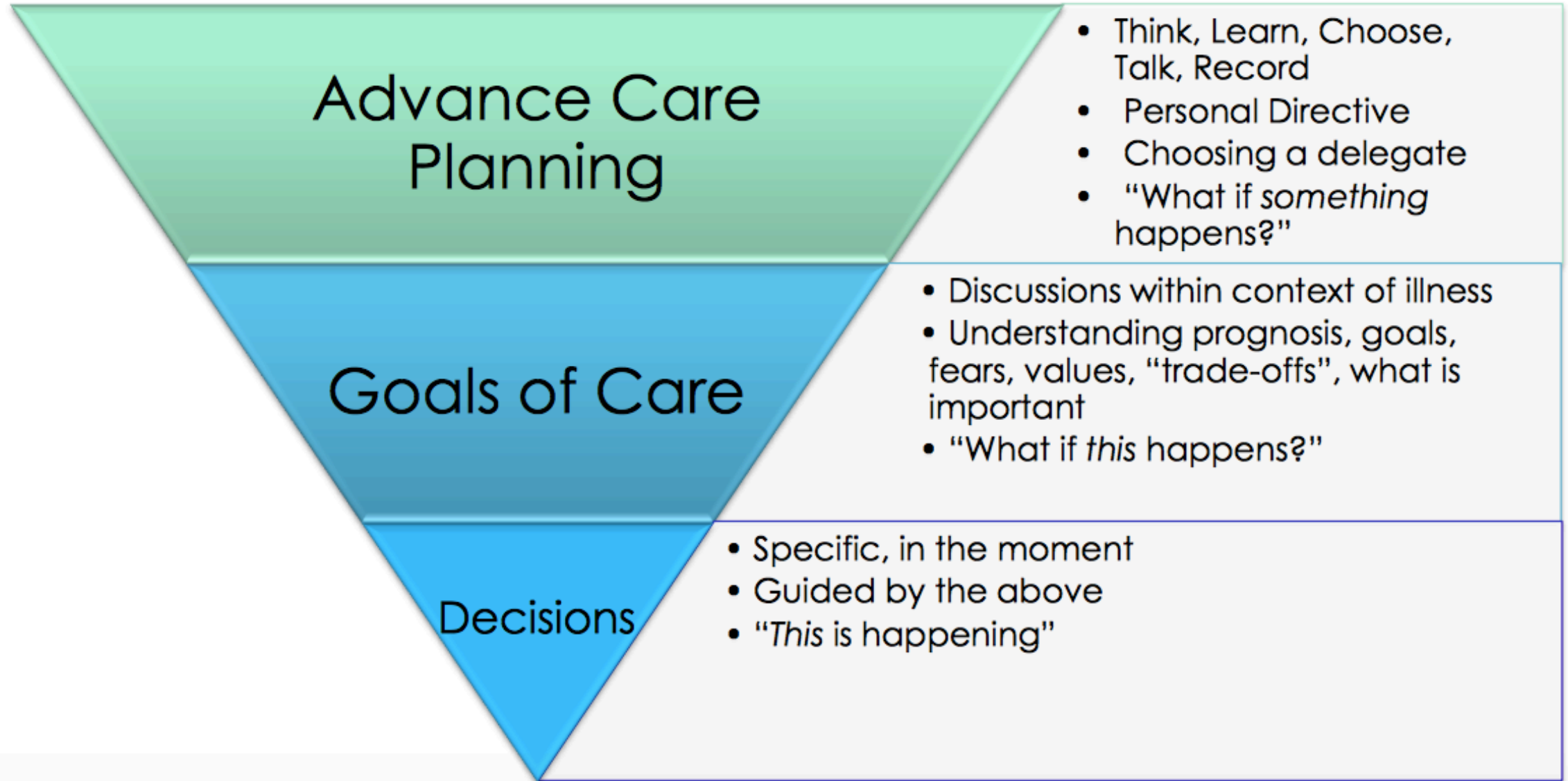
Source-Allen, 2012¹¹

Advance Care Planning

Goals of
Care



Code Status



Decisional Readiness

“What would it be like if you got sicker?”

- *“I know we are hoping that things will go well for a long time but I wonder if we should prepare in case things don’t go as well as we hope.”*

The goal is to make sure that I have all of the information I need about what matters most to you so I can provide you with the care you want, and so I can best support your family if they ever have to make decisions for you.”

Practical Approach to Difficult Conversations

- Recognize important barriers:
 - Unpredictable nature of heart failure
 - Challenge in prognostication
 - Complex emotions associated with the “roller coaster” of heart failure
 - Our own bias
 - “Prognostic paralysis”
 - Time consuming

Johnson et al. *J Pain Symptom Manage*. 2014 Mar;47(3):652-8.

Timmons, MJ et al. *Palliat Care*. 2013 Using Heart Failure instruments to determine when to refer heart failure patients to palliative care Winter;29(4):217-24.

Alba, A. et al. Risk Prediction Models for Mortality in Ambulatory Patients with Heart Failure. *Circ Heart Fail*. 2013;6:881-889

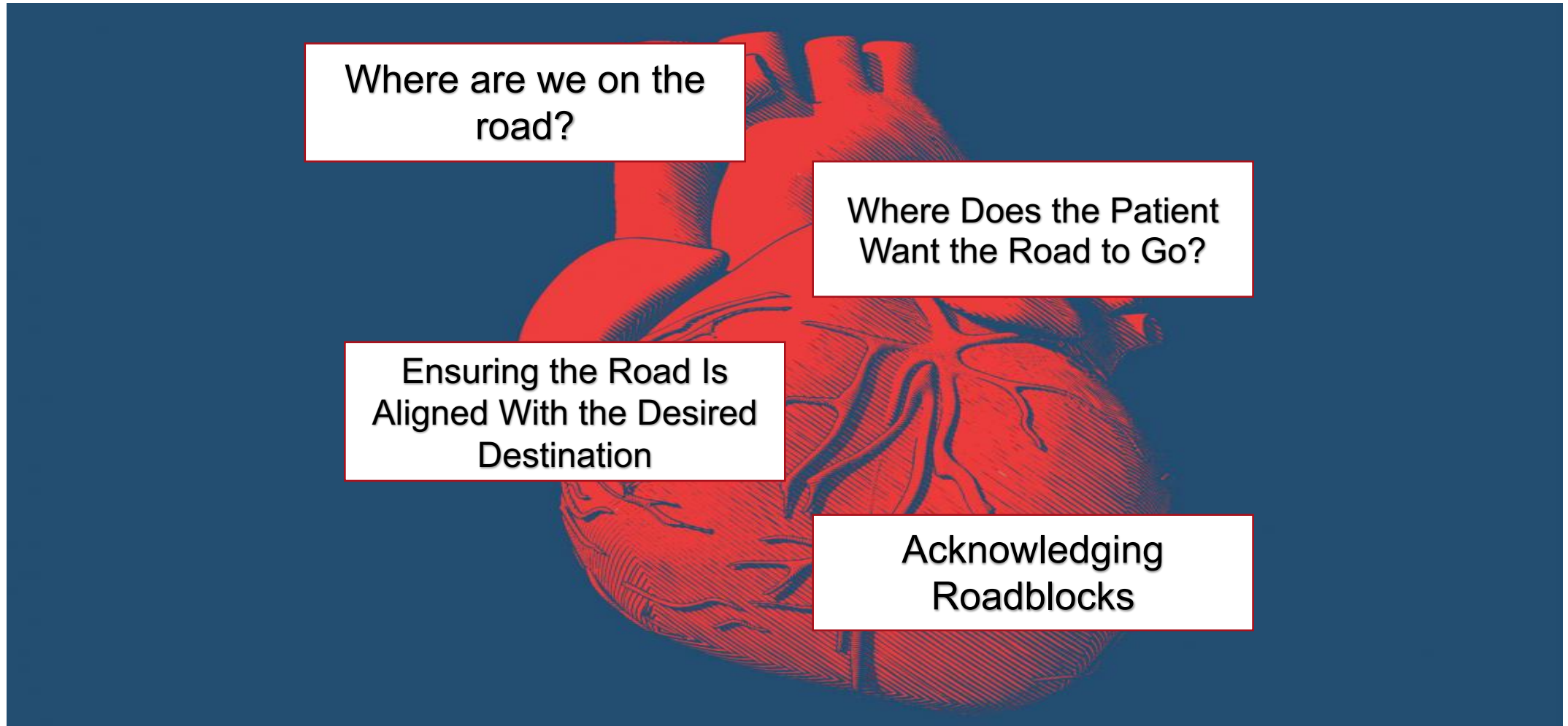
Downar et al. *CMAJ* 2017 April 3;189:E484-93

Br J Gen Pract 2011; 61: e49–e62.

Circulation. 1998; 98:648–655

Practical Approach to Difficult Conversations

- AHA “Roadmap to Guide Conversations”



Illness Understanding

- ASK-TELL-ASK
 - Ask:
 - What they know.
 - What they want to know: “Would you want to know everything about your illness or the treatments we are considering, even if it wasn’t good news?”
 - Tell:
 - Inform.
 - Ask
 - Determine the level of understanding.



Illness Understanding

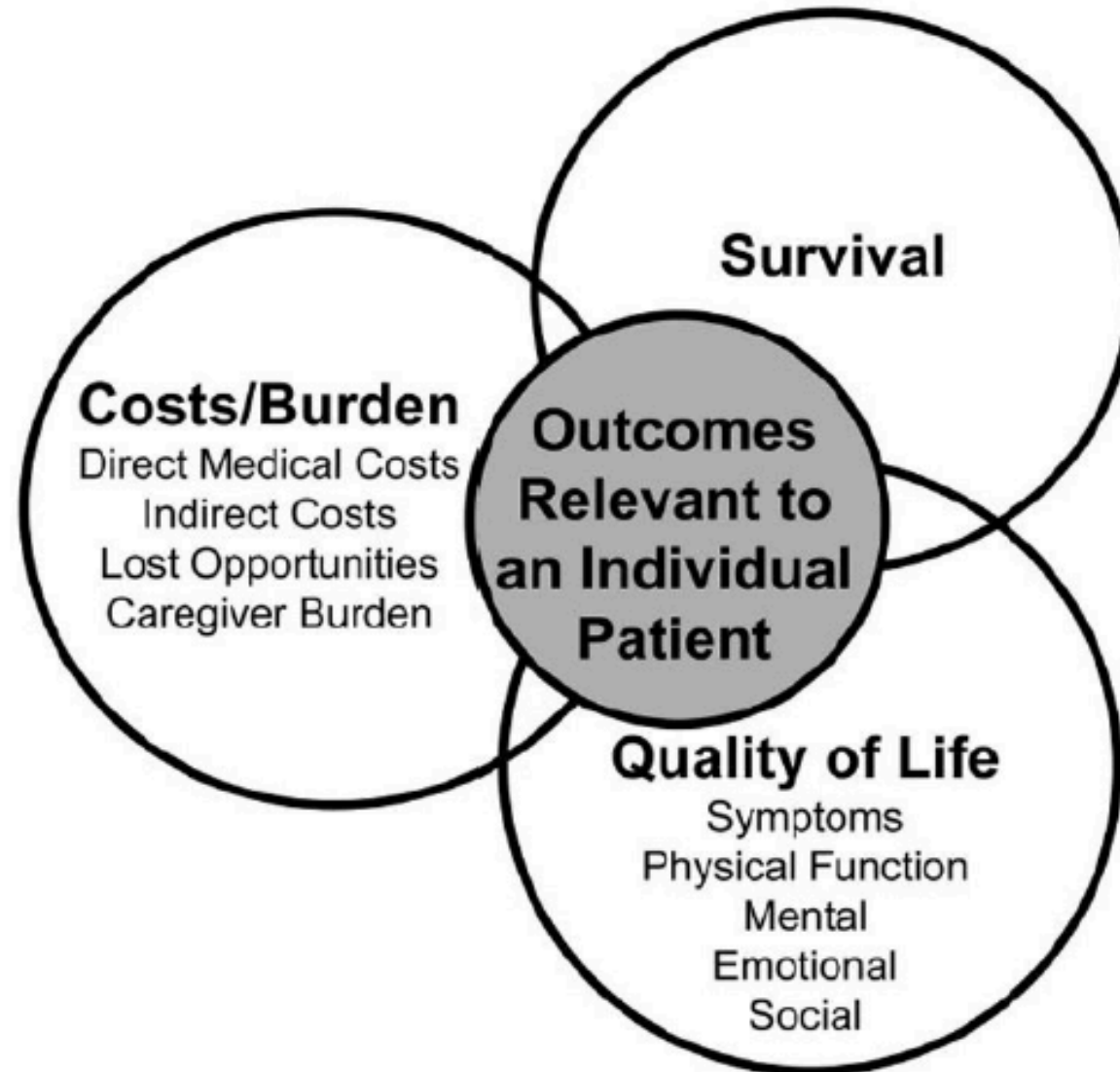
“I’ve read the medical chart... but it helps me to know what has happened from your perspective”

“What have you learned from the other doctors so far?”

“How much information about what is likely to be ahead with your illness would you like from me?”



Establishing Goals and Values



Establishing Goals and Values

“What is important to you now?”

“What abilities are so critical to your life that you cannot imagine living without them?”

“When you think about the future, what are the things you want to avoid?”



Establishing Goals and Values

- What do I value most in terms of my mental and physical health?
 - being able to live independently?
 - being able to recognize others?
 - being able to communicate with others?
 - being able to live as long as possible?
- What would make prolonging life unacceptable for me?
 - not being able to communicate with those around me?
 - being kept alive with machines?
 - not having control of my bodily functions?



Establishing Goals and Values

- When I think about death, is there anything I worry about happening to me?
- If I were nearing death, what would make it peaceful for me?
 - having my family and friends nearby?
 - dying at home? dying somewhere other than home?
 - having spiritual rituals performed?
 - not being a burden to my family?

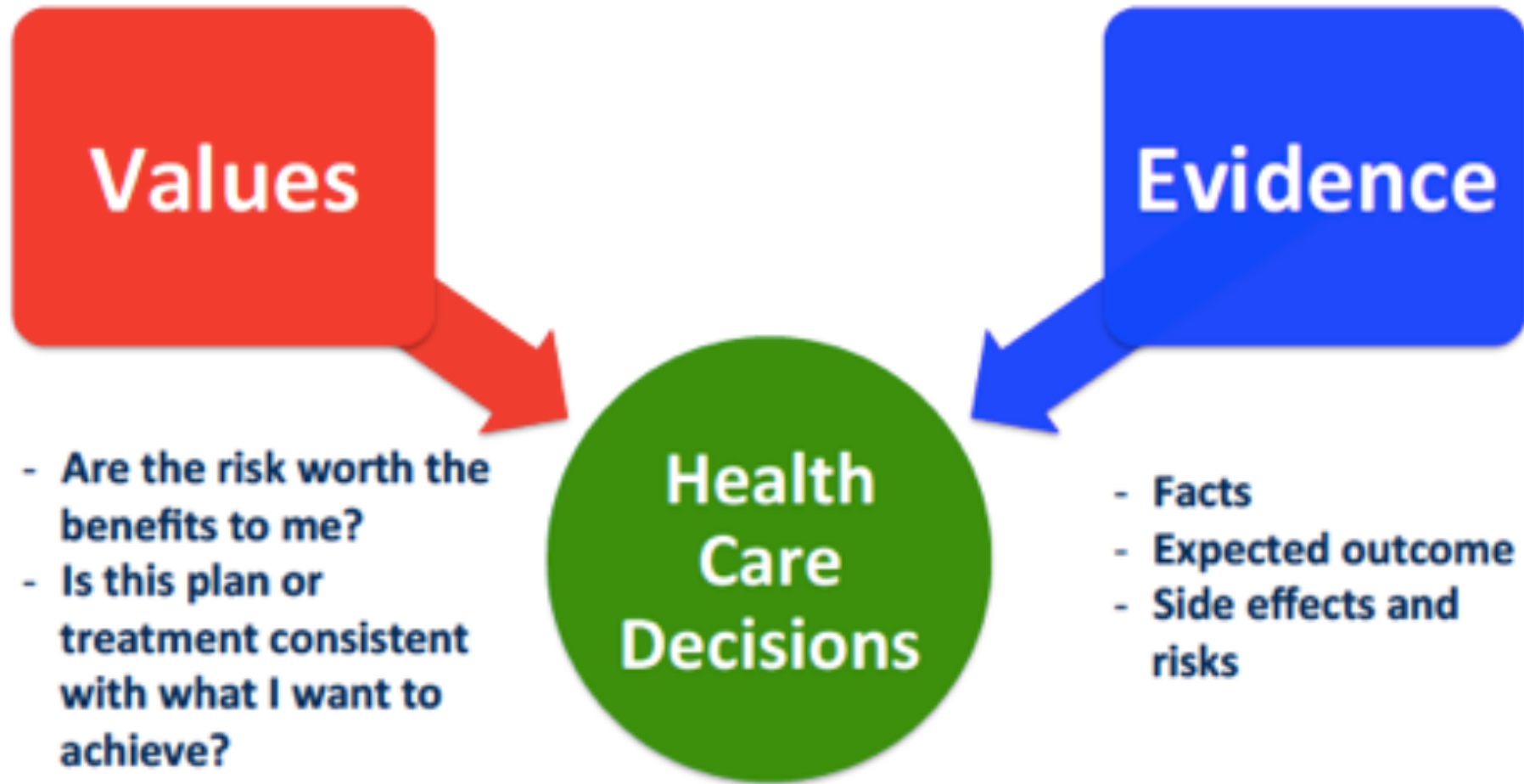


Sharing Prognosis

- *“It can be difficult to predict what will happen with your illness. I **hope** you will continue to live well for a long time but I **worry** that you could get sick quickly and I think it’s important to prepare for that possibility.”*
- *“I **wish** we were not in this situation, but I am worried that time may be as short as (days to weeks, weeks to months, months to a year).”*



Tailoring Treatments to Goals



What if Goals are not achievable?

- Acknowledge the non achievable goal
- Emphasis of the conversation should be on what treatments will still be provided
- 3 Ws = I WISH -- I WORRY -- I WONDER
 - “I wish I could tell you that doing [specific treatment] will accomplish the goals that you have outlined, but I worry that it will not.”
 - “I hope that you can, but I worry that it may not be possible.”
- Clarify what further information is needed to reconcile any inconsistencies
 - “Tell me more about how you think CPR would help you”



Emotional Roadblocks

NURSE mnemonic

- Name: State the patient's emotion
- Understand: Empathize with and legitimize the emotion
- Respect: Praise the patient for strength
- Support: Show support
- Explore: Ask the patient to elaborate on the emotion



Advance Care Planning – Resources

Speak Up | ADVANCE CARE PLANNING WORKBOOK

Learn More ▾

Make a Plan

A Palliative Approach to Care



The Five Steps of Advance Care Planning



Make Your Plan Today

It's easy with our free online workbook.

Start Making My Plan >

(Don't worry, you can save and return at any time!)

What is Advance Care Planning ?

Advance Care Planning is a process of thinking about and sharing your wishes for future health care. It can help you tell others what

www.myspeakupplan.ca



Implantable Cardioverter Defibrillator (ICD) Deactivation

A Guide for Health Care Professionals



When to Consider Implantable Cardioverter Defibrillator (ICD) Deactivation

A Guide for Patients and Family



Specific decision points or triggers for conversations about possible device deactivation may include the following situations:

- Prior to implantation at the time of consultation, as part of the informed consent process;
- When requested by a patient or family member;
- During assessment for device replacement (elective replacement due to battery depletion or advisory);
- Multiple shocks being delivered as a result of disease progression;
- A change in clinical status; worsening of condition or new comorbid condition with a poor prognosis (e.g. advanced malignancy);
- Repeated hospitalizations for heart failure;
- Repeated emergency department visits;
- Refractory symptoms of a cardiac condition despite optimal therapy;
- Deemed ineligible for advanced heart failure therapies (e.g. mechanical circulatory support or transplant);
- Deteriorating quality of life;
- The presence of a DNR order;
- When referred to hospice or a nursing home facility; and
- At a minimum, during annual device clinic visit, or during other device clinic visits.

Tips for discussion on ICD deactivation

- Ask about prior experience with shocks
- Discuss purpose of ICD
- Quantity vs. Quality of life
 - “The ICD will not fix the underlying problem.”

Treatment of Non Cardiovascular Symptoms

Edmonton Symptom Assessment System: (revised version) (ESAS-R)

Please circle the number that best describes how you feel NOW:

No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Pain
No Tiredness (Tiredness = lack of energy)	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Tiredness
No Drowsiness (Drowsiness = feeling sleepy)	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Drowsiness
No Nausea	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Nausea
No Lack of Appetite	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Lack of Appetite
No Shortness of Breath	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Shortness of Breath
No Depression (Depression = feeling sad)	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Depression
No Anxiety (Anxiety = feeling nervous)	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Anxiety
Best Wellbeing (Wellbeing = how you feel overall)	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Wellbeing
No _____ Other Problem (for example constipation)	0	1	2	3	4	5	6	7	8	9	10	Worst Possible _____

Mr. W. C.

Edmonton Symptom Assessment System:
(revised version) (ESAS-R)

Please circle the number that best describes how you feel NOW:

No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Pain
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No Nausea	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Nausea
No Lack of Appetite	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Lack of Appetite
No Shortness of Breath	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Shortness of Breath
No Depression (Depression = feeling sad)	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Depression
No Anxiety (Anxiety = feeling nervous)	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Anxiety
Best Wellbeing (Wellbeing = how you feel overall)	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Wellbeing
No _____ Other Problem (for example constipation)	0	1	2	3	4	5	6	7	8	9	10	Worst Possible _____

The Symptom Burden of HF

- Higher symptom burden compared to those with advanced cancer.
- Higher rates of depression.
- Lower spiritual wellbeing.

Dyspnea

- Non pharmacological
 - Rehabilitation/physical activity
 - Supplemental oxygen if hypoxia
 - Hand held fan
 - Mindfulness psycho education

Dyspnea

- Optimize guideline-directed therapy
- Diuretics
- Inotropes
- Opioids:
 - Literature suggests safe in patients with HF
 - Mixed results in patients with HF
 - Remains first line recommendation for refractory symptoms

Pain

- Common in HF but underdiagnosed.
- **Mild pain:** acetaminophen.
- **Moderate to severe pain:** Opioids as first-line therapy, oral route, regular dosing, titrate dose according to pain intensity on ESAS scale until adequate relief
- Avoid NSAIDs and Codeine.
- Consider complementary medicine options
- Insufficient data to support cannabis use, may be used as adjunct

Nausea

- Reported in 15-50% of patients with HF.
- Etiology likely multifactorial:
 - Intestinal edema
 - Hepatic congestion
 - Reflux
 - Hepatic and/or renal dysfunction
 - Drugs
 - Reduced intestinal blood flow

Nausea

1. Prokinetics:

- Metoclopramide 5-20 mg po/iv/sc q6h PRN
 - Antiemetic drug of choice
 - Evidence to support its use including RCT

Be aware QT
prolongation!

2. Dopamine Antagonists

- Haldol 0.5-1 mg po/iv/sc q4h prn
 - Cochrane review 2015: No RCTs for PO/IV/SC route.
- Olanzapine 2.5-5 mg po/sc qhs +/- q4h prn
- Methotrimeprazine (Nozinan) 5-10 mg po or 6.25-12.5 mg po/sc/iv q4h prn

3. Cannabinoids

- Insufficient evidence to support its use, can be considered if first and second line ineffective.

4. Serotonin Antagonists

- Ondansetron: poor evidence to support its use, not covered.

Fatigue

- Optimize guideline-directed therapy
- Rehabilitation
- Rule out sleep disordered breathing, iron deficiency, depression

Anorexia and Cachexia

- Optimize HF therapy
 - ACEIs and carvedilol have demonstrated favourable effects on metabolism and cachexia.
- Nutritional supplements
 - No evidence that clinical outcomes are improved.
- Avoid dexamethasone.
- Insufficient data to support cannabis use.

Pharmacol Ther 2009;121(3):227-52

Journal Palliative Medicine. Volume 22, Number 3, 2019

J Cachexia Sarcopenia Muscle. 2018. Apr 9(2):220-234

Medical cannabis use in palliative care: clinical effectiveness and guidelines. Ottawa: CADTH; 2018 Sep. (CADTH rapid response report: summary of abstracts).

Insomnia

- Multifactorial: dyspnea, anxiety, pain, sleep-disordered breathing
- Sleep hygiene practices
- Zopiclone may help but increases risk of falls in older patients
- Methotrimeprazine (Nozinan) very sedating
- Evidence does not support use of cannabis.

Constipation

- Stimulant laxative
 - Sennosides
- Osmotic agent
 - PEG 3350 17 g in 250 mL of fluid.
- Do not use fibre if fluid restricted.

Depression

- Use low-dose SSRIs as first-line therapy
 - Sertraline and venlafaxine safe in HF.
 - Avoid tricyclic antidepressants.
- Cognitive-behavioural therapy, spiritual support, mindfulness-based training, and dignity therapy
 - Not supported by RCT evidence

Back to Mr. W.C.

“When I was in England I experimented with marijuana a time or two, and I didn’t like it. I didn’t inhale it, and never tried it again.”



Cannabis 101

- Tetrahydrocannabinol (THC)
- Cannabidiol (CBD)
- Exact amount of active forms of THC + CBD unclear in majority of Cannabis oil purchased
- Nabiximols:
 - Combination THC and CBD, available as oro-mucosal spray
 - Expensive
 - Evidence for neuropathic pain and spasticity
- Nabilone:
 - synthetic THC, 10x more potent, oral form
 - Approved for chemotherapy induced nausea and vomiting
 - Off label use for pain

Cannabis 101

THC

Analgesia

Anti-nausea

Anti-insomnia

Appetite stimulant

Anti-spasmodic

Psychoactive effects:

Paranoia/anxiety

Euphoria/relaxation

CBD

Analgesia

Anti-nausea

Anti-inflammatory

Anti-psychotic

Anxiolytic

Anti-ischemic

Anti-epileptic

Cannabis Side Effects

THC

Drowsiness, dizziness, dry mouth, anxiety, euphoria, paranoia, toxic psychosis, **tachycardia, orthostatic hypotension**, slowed reaction time, headache, blurred vision, cognitive impairment, and depression.

CBD

Dry mouth, drowsiness, light headedness, hypotension, fatigue, diarrhea, vomiting, fatigue, pyrexia, somnolence.

Cannabis in Heart Failure

- No reports of heart failure associated with its use.
- Case reports include arrhythmia and acute coronary syndrome.

Back to Mr. W.C.

“I don’t want to live like this anymore. I want assisted suicide.”

MAID - Eligibility Criteria

- At least 18 years of age
- Capable of health care decisions
- Grievous and irremediable medical condition
 - Serious and incurable illness, disease or disability
 - advanced state of irreversible decline in capability
 - Enduring physical or psychological suffering, intolerable and cannot be relieved under conditions they consider acceptable
 - Natural death has become reasonable foreseeable
- Voluntary requests for MAID
- Informed consent for MAID

MAID

An expression of suffering

- Data has shown many people change their minds after feeling that their suffering has been heard.

Distinct from Palliative care

Approach to Request for MAID

1. Validate the suffering and the request in a non-judgmental way.

“I am honoured you could talk to me about this.”

“I am always open to explore any feeling or desire that you may have.”

“Tell me about your suffering...”

2. Look for underlying symptoms or conditions that are poorly treated.
3. Explore worries/fears.
4. Demonstrate compassion and commit to non-abandonment & being non-judgmental....

“No matter what you choose to do, I will continue to care for you...”

Conclusion

- Palliative care should be integrated early in the disease course of patients with HF.
- Palliative care integration:
 - Improves quality of life
 - Reduces healthcare utilization.
- Difficult discussions now will simplify difficult decisions in the future.
- Diffusion of primary palliative care can improve ACP and improve quality of life in HF.

Thank you!

